STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155132	B. WING		06/20/2011
NAME OF I	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	-ROVIDER OR SUFFLIE	K	255 ME	EADOW DR	
DANVILL	E REGIONAL REF	HABILITATION	DANVII	LLE, IN46122	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
•	TEL: ::/ C	T	F0000		
		or Investigation of	F0000		
	Complaint IN00	0092018.			
	Commission No.	1 D.100002010			
	Complaint Number IN00092018:				
	Substantiated, Federal/State deficiencies				
		legations are cited at			
	F225, F226, F2	279 and F323			
	Dates of Survey				
	June 17 and 20,	2011			
	Facility Number				
	Provider Number	er: 155132			
	AIM Number:	100266570			
	Survey Team:				
	Vanda Phelps, 1	RN			
	Census Bed Typ	e:			
	12 SNF				
	72 SNF/NF				
	84 Total				
	Census Payor T	ype:			
	19 Medicare				
	56 Medicaid				
	9 Other				
	84 Total				
	Sample: 5				
	These deficience	ies also reflect state			
L A BOR ATOR	V DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R5NK11

Facility ID:

000057

l	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CO A. BUILDING B. WING	00		e survey pleted /2011
	PROVIDER OR SUPPLIER		255 ME	ADDRESS, CITY, STATE, ZIP EADOW DR LLE, IN46122	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	findings cited in 16.2.	accordance with 410 IAC				
	Quality review c 2011 by Bev Fau	ompleted on June 23, alkner, RN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132		(X2) MULT A. BUILDI B. WING		OO	(X3) DATE S COMPL 06/20/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER				ODRESS, CITY, STATE, ZIP CODE		
DANVILL	E REGIONAL REH	ABILITATION	[DANVILL	_E, IN46122		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	·E	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	7	ΓAG	DEFICIENCY)		DATE
F0225 SS=D	have been found gor mistreating residuals have had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities.						
	The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.						
	reported to the add representative and accordance with S State survey and of working days of th	nvestigations must be ministrator or his designated d to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective sen.					
	Based on observation interview, the faction investigate and readingury of unknown	ation, record review and cility failed to thoroughly eport to state agencies an origin for 1 of 5 d for abuse/neglect in the	F022	25	Corrective Actions: An incide report on state form 6-04 has been sent to ISDH regarding identified event. An investigategarding safety device assessment has been	the	07/20/2011

l í		nn Co			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155132	B. WIN	IG		06/20/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
				1	ADOW DR	
DANVILL	E REGIONAL REH	ABILITATION		DANVIL	LE, IN46122	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	sample of 5. (Re	esident T)			completed. The enablers ha been removed and a scoop	ve
					mattress has been implemen	ited
	Findings include	:			IDT reviewed care plan and	
					resident is now an assist of 2	with
	During the orient	tation tour on 6/17/2011			turning and repositioning. Cl	
	at 10:46 a.m., Ro	esident T was identified			has been educated on turnin	- 1
	by RN #2 as havi	ing recently experienced			and repositioningOther resident having the potential to be	enis
	*	orehead from turning in			affected: An audit of residen	ts
		t was observed receiving			who use enablers and/or safe	
	medications at 4 p.m. There was a circular shaped bruise in the middle of her forehead just below the hairline with a fading outline of more bruising which				devices will be completed to	
					identify other residents at risl	
					Any residents identified affect	
					corrections will be completed Systematic changes: Upon	'·
	covered the entire	•			admission, quarterly and with	n
		e left half of her			change of condition, resident	
	forehead.				be assessed for proper safet	
					devices. Any potential repor	table
		ical record was reviewed			event will be brought to the attention of the Regional Dire	octor
		2:55 p.m. Her diagnoses			of Clinical Services and Regi	
	included, but wer	·			Director of Operations (by the	
	Alzheimer's disea	ase. The 5/12/2011			Administrator/DON) for	
	quarterly Minimu	um Data Set assessment			review and reported to the IS	HD
	indicated her cog	nitive skills were			in accordance to	
	severely diminish	ned and she required total			Federal Guidelines. An Accident/incident report will be	ne
	assistance of staf	f for all areas of her daily			completed with all occurance	
	living.				Accident/incident reports will	
					reviewed 5 days a week (mo	
	A nursing note of	f 4/21/2011 at 2 p.m.,			thru Friday excluding holiday	
		s found to have a 4 cm			and weekends). An invesigat will be completed by DON	ion
		cm sized, light blue,			including final	
	l ' -	right temple/eye area. It			dispositon. Administrator will	sign
	"	as "unwitnessed."			off on all accident/incident re	port.
		J #3 on 6/20/11 at 12:55			An in-service regarding abus	e
					and neglect and injury of	
	_	ne was called to the room			unknown origin,which include immediate notification and w	
	by a nurse aide w	when the injury was first				

000057

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155132 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 255 MEADOW DR DANVILLE REGIONAL REHABILITATION DANVILLE, IN46122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE observed. She said the injury was "a golf report incident to, will be completed for staff by 7-20-11. ball sized knot in the mid An in-service for CNA's and forehead...raised about 1/2 inch. The licensed nurses will be completed bruising hadn't started yet." on transfers and repositioning will be completed for by 7-20-11. The Administrator and DON will Another nursing note 6/8/2011 at 1:30 be in-serviced on p.m., indicated a nurse aide reported accidents/incidents of unknown finding a golf-ball sized, purplish, raised origin investigation knot on Resident T's forehead. Another outcomes/conclusion will be completed.Monitoring: Accidents entry, dated 6/11/2011 at 10:25 a.m., and incidents will be brought to indicated, "cont (continues) to have lg clinical triage and the daily clinical (large) hematoma on forehead." review 5 days/week (excluding 6/11/2011 at 6 p.m., indicated, "conts to holidays and weekends) for review to ensure investigation and have bruise covering (1) [left] side of final disposition has been forehead." completed in full to determine if there is an injury of unknown origin to ensure timley reporting. On 6/20/2011 between 11 a.m. and 4 DON and/or designee will p.m., individual interviews of 11 hands-on monitor all accidents and staff (nurses and nurse aides) indicated incidents on a daily basis to Resident T was unable to move herself in ensure ongoing compliance. bed, did not wiggle or squirm, etc. She Accidents and incidents will be reviewed during monthly QA on could call out for ice cream and an ongoing basis for at least 6 sometimes sang hymns, but was unable to months to ensure consistently report pain or hunger. The complianceDate systematic staff indicated that actually, she rarely changes will be completed: 7-20-11 spoke at all. Interview with the Administrator and interim Director of Nursing on 6/20/2011 at 11 a.m., indicated this event had not been reported to ISDH (Indiana State Department of Health) or other state agencies because their internal investigation had concluded Resident T

000057

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPI		
		155132		LDING		06/20/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ADOW DR		
DANVILL	E REGIONAL REH	ABILITATION		DANVIL	LE, IN46122		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		r head on the siderail		IAG			DATE
		ed. No staff had					
		appened, but that was the					
		they could make. Their					
	-	icated the resident was					
	fine at 9 a.m., an	d during lunch, but at					
	1:30 p.m., the inj	ury was noticed while					
	the resident was	lying in bed. The					
	•	ovided notes from a daily					
	meeting on 4/22/2011 that noted the unit						
manager reported a Certified Nurse Aide							
	(CNA #1) had reported she had bumped						
	Resident T's head on the side rail when						
	she turned her.						
	Review of the fa	cility's investigation of					
		ry of unknown origin					
		typed notes of staff					
		acked a conclusion of any					
		igation regarding the					
		had not been conducted					
	other than the sta	and up meeting notes.					
	On 6/20/2011 at	3:30 p.m., upon review					
	of nursing sched	ules and assignment					
		011 and 6/20/2011,					
	during another in						
		d interim Director of					
	_	oted the same nurse					
		d been assigned to care					
		n both dates. Until this					
	-	investigations had not					
	made this connec	Ction.					
							<u> </u>

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
11112 12111	or condition.	155132	A. BUILDING B. WING		06/20/2011
NAME OF B	DOWNER OF CURRY IED			ADDRESS, CITY, STATE, ZIP CODE	
	ROVIDER OR SUPPLIER		l l	ADOW DR	
	E REGIONAL REH		DANVIL	LE, IN46122	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE DATE
	Review of CNA	#1's personnel file on			
	6/20/11 at 4:47 p	.m., indicated there were			
		ctions or teachable			
		ntation in her file.			
	Interview at the t				
		d interim Director of			
	•	ed this observation. CNA			
		ical LOA during this			
	investigation and not available for interview.				
interview.					
	This federal tag relates to complaint				
	IN00092018.	•			
	3.1-28(c)				
	3.1-28(d)				
F022 (The facility may style	avalan and implantant			
F0226 SS=D	_	evelop and implement d procedures that prohibit			
00-D	mistreatment, neg	lect, and abuse of residents			
		ion of resident property.	7000	O	
		ation, record review and	F0226	Corrective Actions: An incide report on state form 6-04 has	
		acility failed to follow its		been sent to ISDH regarding	•
		otocol when 1 of 5		identified event. An investiga	ation
	residents sampled for abuse/neglect issues in a sample of 5 was found with a knot in			regarding safety device assessment has been	
	_	forehead. This resident		completed. The enablers ha	ıve
		dependent and unable to		been removed and a scoop	-td
		ppened. Further the		mattress has been implemer IDT reviewed care plan and	ileu.
		report this injury of		resident is now an assist of 2	2 with

I '		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155132	B. WIN			06/20/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	ADOW DR		
DANVILI	LE REGIONAL REH	ABILITATION		1	LE, IN46122		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	unknown origin to the State Agency or to				turning and repositioning. Cl		
	conduct a compr	rehensive investigation			have been educated on turni	_	
	_	_			and repositioningOther resident	ents	
	regarding the event. (Resident T) Findings include:				having the potential to be affected: An audit of residen	to	
					who use enablers and/or safe		
					devices will be completed to	Cty	
					identify other residents at risl	ζ.	
	_ ~	tation tour on 6/17/2011			Changes or adaptations will	be	
	1	esident T was identified			made as needed. Systemation	;	
	by RN #2 as hav	ring recently experienced			changes: Upon admission,		
	a bruise on her forehead from turning in				quarterly and with change of		
	bed. She was observed receiving				condition, residents will be assessed for proper safety		
	medications at 4	p.m. There was a			devices. Any potential repor	table	
		oruise in the middle of her			event will be brought to the		
	_	ow the hairline with a			attention of the Regional Dire	ector	
	1	Emore bruising which			of Clinical Services and Regi		
	"	· ·			Director of Operations (by the	е	
	covered the entir	te left half of her			Administrator/DON) for	D	
	forehead.				review and reported to the IS in accordance to	HD	
					Federal Guidelines. An		
	Resident T's clin	ical record was reviewed			Accident/incident report will to	e l	
	on 6/17/2011 at 2	2:55 p.m. It indicated			completed with all occurance		
	she had been a re	esident since 1998. Her			Accident/incident reports will		
	diagnoses includ	led, but were not limited			reviewed 5 days a week (mo		
	_	disease. The 5/12/2011			thru Friday excluding holiday		
	l ´	Minimum Data Set)			and weekends). An invesigat will be completed by DON	IUII	
	1 * *	eated her cognitive skills			including final		
		nished and she required			dispositon. Administrator will	sign	
	1	of staff for all areas of her			off on all accident/incident	•	
		or starr for all areas of fier			reports. An in-service regard		
	daily living.				abuse and neglect which incl		
					immediate notification and w	no to	
	A nursing note of 4/21/2011 at 2 p.m., indicated she was found to have a 4 cm				report incident to, will be completed for staff by 7-20-1	, l	
					An in-service for CNA's and	1.	
	(centimeter) by 1	l cm sized, light blue,			licensed nurses will be comp	leted	
	bruise along her	right temple/eye area. It			on transfers and repositionir		
	1	as "unwitnessed."			will be completed for by 7-20	D-11.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155132 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 255 MEADOW DR DANVILLE REGIONAL REHABILITATION DANVILLE, IN46122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The Administrator and DON will be in-serviced on Another nursing note 6/8/2011 at 1:30 accident/incident reporting to p.m., indicated a nurse aide reported ISDH in accordance to federal finding a golf-ball sized, purplish, raised guidelines. Monitoring: Accidents and incidents will be brought to knot on Resident T's forehead. Another clinical triage and the daily clinical entry dated 6/11/2011 at 10:25 a.m., review 5 days/week (excluding indicated, "cont (continues) to have lg holidays and weekends) for (large) hematoma on forehead." review to ensure investigation and 6/11/2011 at 6 p.m., indicated, "cont. to final disposition has been completed in full to determine if have bruise covering (1) [left] side of there is an injury of unknown forehead." origin to ensure timley reporting. DON and/or designee will On 6/20/2011, between 11 a.m. and 4 monitor all accidents and incidents on a daily basis to p.m., individual interviews of 11 hands-on ensure ongoing compliance. staff (nurses and nurse aides) indicated Accidents and incidents will be Resident T was unable to move herself in reviewed during monthly QA on an ongoing basis to ensure bed, did not wiggle or squirm, etc. She complianceDate systematic could call out for ice cream and changes will be completed: sometimes sang hymns, but was unable to 7-20-11 consistently report pain or hunger. The staff indicated that actually, she rarely spoke at all. Interview with the Administrator and interim Director of Nursing on 6/20/2011 at 11 a.m., indicated this event had not been reported to ISDH (Indiana State Department of Health) because their internal investigation had concluded Resident T must have hit her head on the siderail while being turned. No staff had admitted it had happened, but that was the only conclusion they could make. Their investigation indicated the resident was

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132			ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL 06/20/2	ETED	
		100102	B. WIN		DDDEGG OFFI CARE ZID CODE	00/20/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE ADOW DR		
	LE REGIONAL REH			1	LE, IN46122		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	d during lunch, but at					
	1:30 p.m., the injury was noticed while						
	1	lying in bed. The					
	1	rovided notes from a daily					
		/2011 which noted the					
	1 .	ported a Certified Nurse					
	· ` ′	had reported she had					
	1 -	t T's head on the side rail					
	when she turned	her.					
	Review of the facility's investigation of						
	the 6/7/2011 injury of unknown origin						
	indicated it was typed notes of staff						
	interviews, but la	acked a conclusion of any					
	kind. An invest	igation regarding the					
	4/21/2011 event	had not been conducted					
	other than the sta	and up meeting notes.					
	On 6/20/2011 at	3:30 p.m., upon review					
	of nursing sched	ules and assignment					
	sheets for 4/21/2	011 and 6/20/2011,					
	during another in	nterview with the					
	Administrator ar	nd interim Director of					
	Nursing, it was i	noted the same nurse					
	aide/CNA #1 had	d been assigned to care					
	1	n both dates. Until this					
	time, the facility	investigations had not					
	realized this con	_					
	Review of CNA	#1's personnel file on					
	1	o.m., indicated there were					
	_	ections or teachable					
		entation in her file.					
	Interview at the						

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE S	
THID TETH	or conduction	155132	A. BUII			06/20/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIER			255 ME	ADOW DR		
DANVILI	E REGIONAL REH	ABILITATION		DANVIL	LE, IN46122		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
	<u> </u>	d interim Director of					
		ed this observation. CNA					
	#1 was on a medical LOA during this						
	investigation.						
	Paviaw 6/20/201	1 at 1 p.m., of the					
	facility's current abuse/neglect protocol						
	provided for revi	• •					
	following excerpts:						
	"Injuries of Unknown Source * The source of the injury was not observed by any person or the resident						
	1	the source of the					
	injury."	the source of the					
	5						
	"Investigation						
		ccidents and Incidents:					
		tion, Follow-Up and					
	_	edure located in the					
	manual.						
	2. Collect data	on the Accident/Incident					
	Report						
	3. Initiate the in	vestigation:					
		ent of unknown origin by:					
		g the algorithm					
		cident of Unknown					
	Origin."						
	" 3 Report all	alleged violations and all					
		idents to the state agency					
		gencies as required, and					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
111,2 12,11,	or condition,	155132	A. BUILDING B. WING		06/20/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
	E REGIONAL REH		I	ADOW DR LLE, IN46122	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	_LE, IN40122 I	(7/5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		y corrective actions			
	depending on the investigation.	e results of the			
	mvestigation.				
	7. Report result	s of investigation to the			
		s as required by State			
	law, including the state survey and				
	days."	ncy within five working			
	augo.				
	This federal tag relates to complaint				
	IN00092018.				
	3.1-28(a)				
	3.1-28(e)				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155132	B. WING		06/20/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER		255 M	EADOW DR	
	E REGIONAL REH	ABILITATION		ILLE, IN46122	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE
F0279	A facility must use	the results of the velop, review and revise the			
SS=D		nensive plan of care.			
	resident's compret	ichaive plan of care.			
	The facility must d	evelop a comprehensive			
	care plan for each	resident that includes			
	measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the				
comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,					
		osocial well-being as			
		83.25; and any services that			
		e required under §483.25 ed due to the resident's			
	•	under §483.10, including the			
		tment under §483.10(b)(4).			
	_	ation, record review and	F0279	Corrective Action: Resident	07/20/2011
		cility failed to develop		Tcareplans have been review	ved
		reflected the changing		and updated to reflect	.
	•	idents. Further, the care		individualizion and organized	
		· · · · · · · · · · · · · · · · · · ·		manner. Resident P careplar have been reviewd and upda	
	practice affected	vidualization. This		to reflect individualization an	
	*			organized manner. Resident	I
		e plans in the sample of		careplans have been reviewe	∍d
	5. (Residents L,	P and I)		and updated to reflect	
			1	individualization in an organi manner. Other residents have	
	Findings include	:		the potential to be affected:	/iiig
				Residents that reside in the	
	1. Resident T's cl	linical record was		facility who have a	
	reviewed on 6/17	7/11 at 2:55 p.m.		comprehensive care plan ha	
	Nursing notes in	dicated she'd had two		the potential to be affected b	· I
	incidents with an unexplained knot, abrasion and bruising to her forehead on			alleged deficient practice. As audit will be completed by 7-	
				of residents careplan to ensu	
	4/21/11 and again			careplans reflect individuality	
				an organized manner. Any	

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	or conduction	155132	A. BUI		00	06/20/2	
		1.00.102	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	
NAME OF I	PROVIDER OR SUPPLIER	₹		1	ADOW DR		
DANVILL	E REGIONAL REH	ABILITATION		1	LE, IN46122		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Director of Nurs indicated a CNA had admitted she the siderail (white enablers) while the been unable to do what had happen attributed it to the Review of the careviewed on 6/16 was not care plan were all preprint completed by plan what the writer of fitting place to an need/intervention. The interim Directly during an intervithat this issue has the section titled Assessment: Preplan of Care." The listed: "At risk receive at Risk (10 [checkmark] Brascore at Risk (10 [checkmark] Surshifts	ector of Nursing indicated ew on 6/20/11 at 3 p.m., d been addressed under "Skin Integrity evention and Treatment The Assessment column elated to: aden Risk Assessment 0-12) crease frequency of pplement with Small			careplans identified as defici-will be updated. Systematic changes: Careplans are initi at admission, quarterly and with change of condition. Reside careplans will be updated an reviewed during daily clinical review 5 days/week (excluding weekends and holidays). An ongoing review of careplans be completed during weekly careplan meetings to ensure careplans reflect the most resident (s). Monitoring: The Clinical Reimbursement Coordinator and/or Clinical Reimbursement Specialist with monitor the updating, compliand organization of the resident careplan weekly to ensure compliance. Careple with identified concerns will be brought daily to DCR (5 days/week excluding holiday weekends) to ensure individualization and organization and organization x 3 months the reviewed on a weekly basis the ensure individualization and organization x 3 months there quarterly thereafter unless the committee determines otherwise. Date sytematic changes will be completed: 7-20-11	ated vith nt d ng will cent vidual ill etion ans be s and ation.	
		aximal Remobilization,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155132	B. WIN			06/20/2	011
NAME OF I	DD OWIDED OD GUIDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF			255 ME	ADOW DR		
	LE REGIONAL REH				LE, IN46122		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAU	[checkmark] Pro	· · · · · · · · · · · · · · · · · · ·		IAU	2-2-10-2-17		DATE
	1 -						
	Friction and She	nage Moisture, Nutrition,					
		17/11 place flat sheet at					
	top of bed						
	[checkmark] no	•					
	1 *	wel incontinence					
	1 *	adder incontinence					
	1 -	e appropriate Mood and					
	Behavior Symptoms Assessment/Plan of						
	Care						
	[checkmark] See Plan of Care, Pain						
	Management,						
	1 *	e appropriate Depression					
	Mood and Behav	* *					
	1	n of Care, [checkmark]					
	dermal fragility						
	1	ear, mid spine healed					
	5/23/11						
	1	in tear LFA (left forearm)					
	[checkmark] Al						
	[checkmark] De						
	1 * * *	ints bilateral hand					
	1 *	/11 bruise to left side					
	forehead	·					
	[checkmark] pa						
	1	nder joints, swollen joint					
	[checkmark] ost						
	[checkmark] pul	_					
		adder incontinence					
	[checkmark] de						
	[checkmark] ve						
	[checkmark] vis	-					
	[checkmark] car	diovascular meds					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND FLAN	OF CORRECTION	155132	A. BUIL		00	06/20/2	
		100102	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	
NAME OF I	PROVIDER OR SUPPLIER				ADOW DR		
DANVILL	E REGIONAL REH	ABILITATION			LE, IN46122		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	[checkmark] ant	1 2					
	[checkmark] Ho	yer for transfer needed."					
	The goals were	haalrad og fallavyg					
	•	hecked as follows:					
		7/11 will not develop					
	skin against Stat	ue from (illegible word)					
	_	demonstrate healing					
		nptoms of infection					
	"	•					
	[checkmark] will remain free of open						
	areas [written in] resident will be turned and						
	repositioned with						
	1 ^	to use draw sheet and be					
	aware of bed place						
	1	l be free of a serious					
	injury if a fall wo						
	injury ir a ran we	ould occur					
	The interventions	s were checked as					
	follows:						
	[checkmark] cor	nplete push tool weekly					
	[checkmark] cor	nplete Braden Scale upon					
	admission and w	eekly times 4 wks,					
	quarterly and wit	th change of condition					
	[checkmark] Use	e Commercial Moisture					
	Barrier						
	[checkmark] Use	e Absorbent Pads or					
	Diapers that Wic	k & Hold Moisture					
	[checkmark] Suj	pplement with					
	Multi-Vitamin (s	hould have vitamin A,					
	C, & E)						
	[checkmark] Co	nsult Dietitian prn (when					
	needed)						
	[checkmark] Ele	evate HOB (head of bed)					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBE	ER:			STRUCTION 00		(X3) DATE COMPL	
1111212111	or condition.	155132	<i>f</i>	A. BUILDIN	\G			06/20/2	
			<u> </u>	B. WING	TREET ADI	DRESS, CITY, STA	TE_ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹				DOW DR	IL, ZII CODE		
DANVILL	E REGIONAL REH	IABILITATION				E, IN46122			
(X4) ID		STATEMENT OF DEFICIENC			D	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PERCEDED I			EFIX	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIATI ICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFOR	MATION)	1.	AG	DEFI	CHENCI)		DATE
	no more than 30	•							
	Resident	e Lift Sheet to move							
	[checkmark] Protect Elbows and Heels if								
	being Exposed to								
	[checkmark] Ma	aintain Good Hydrat	tion						
	[checkmark] Av	checkmark] Avoid Drying the Skin							
	[checkmark] Bathe with mild soap, rinse,								
	and dry thorough	and dry thoroughly							
	[checkmark] moisturize skin with lotion								
	to keep the skin soft and pliable,								
	especially bony prominence								
	[checkmark] keep skin clean, dry, and								
	free of body was	stes, perspiration, an	d						
	wound drainage								
	[checkmark] end mobility as toler	courage ambulation	and						
	1 *	ovide ROM (Range	of						
	Motion) as appl	` •							
		sition body with pill	lows						
	and/or other sup								
	1	ep linen dry and wri	nkle						
	free								
	[checkmark] pro	otect elbows and hee	els as						
	needed								
	[checkmark] po	sition calves on pillo	ows to						
	elevate heels off	of the bed							
	[checkmark] Se	e ADL/Mobility Pla	an of						
	Care								
	[checkmark] Lit	ftdo not slide resid	ent						
	[checkmark] use assistive device to								
	reduce friction and facilitate resident								
	movement such as: turning sheets,								
	overbed trapeze,	resident lift, etc							
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete	Event ID: R5N	NK11	Facility ID:	000057	If continuation sh	eet Pa	ge 17 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE COMPL		
		155132	A. BUI B. WIN	LDING		06/20/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			255 ME	ADOW DR		
	E REGIONAL REH			DANVIL	LE, IN46122		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		e Alteration in Urinary	+	1110			DATE
	Continence/Plan						
		e Alteration in Bowel					
	Elimination/ Plan						
		onitor Nutrition and					
	hydration status						
	[checkmark] See	e Medication					
	Administration R	Record (MAR)					
	[checkmark] Mo	onitor wound weekly and					
	PRN						
	[checkmark] See Skin Grid- -Pressure/Venous Insufficiency						
	Ulcer/Other						
	[checkmark] Pro	ovide treatment per MD					
	order						
		date MD within 2-4					
	weeks if no evide	•					
		nirts on during transfers					
		Hoyer pad to prevent					
	shearing on mid-	*					
		eves per MD order					
	[added] Bacitrac	•					
		be educated on proper					
	~	ent care to prevent future					
	bruising during ([checkmark] See						
	Circulatory Plan						
		e ADL/Mobility Plan of					
	Care	TYPE/MOUIITY I IAII UI					
		e Plan of Care: Pain					
	Management	or rail or Carc. I alli					
	_	e Alteration in Bowel					
	'	essment/Plan of Care					
		e Alteration in Bladder					
	[[]]]				l		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPI	LETED
		155132	B. WIN			06/20/2	011
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIE	3			ADOW DR		
DANVILI	E REGIONAL REH	IARII ITATION		1	LE, IN46122		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG	Continence Plan	· · · · · · · · · · · · · · · · · · ·	+	IAG			DAIL
	[checkmark] Lo						
		gh back wheelchair, tilt					
	back wheelchair						
	[checkmark] nig	ght light					
	[checkmark] no	n skid socks					
	There were mult	iple duplications and					
	interventions wh	nich were not relevant for					
	Resident T. Fu	rther one intervention said					
	to avoid drying the skin and the very next						
	intervention said to dry thoroughly.						
		ons related to ambulation,					
	which this reside	ent could not do.					
		Resident L's record was					
		at 1:17 p.m. The 5/27/11					
	annual RAI (Re	sident Assessment					
	Instrument) indi	cated this resident is					
	cognitively intac	et and able to					
	communicate we	ell. She had one fall					
	without injury si	nce the previous review.					
	The care plan co	ontained an entry					
	regarding falls w						
	The problem sta	tements were as follows:					
	[checkmark] an						
	[checkmark] an	•					
	[checkmark] ne						
		-					
	[checkmark] pe						
	[checkmark] tar	-					
	[checkmark] sci						
	[checkmark] pe	ripheral vertigo (listed					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155132	B. WIN			06/20/20	11
NAME OF E	PROVIDER OR SUPPLIER	<u>I</u>	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDER OR BUTTELEN				ADOW DR		
DANVILL	LE REGIONAL REH	ABILITATION		DANVII	_LE, IN46122		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	again)						
	[checkmark] gai	t disturbance					
	The goal was identified as:						
		ll be free of a serious					
	injury if a fall wo	ould occur					
		11 4 1 0 11					
	The interventions were listed as follows:						
		st use walker verbal					
	reminders education on proper use						
	[checkmark] See ADL/Mobility Plan of						
	Care						
	[checkmark] Rea	acher to assist with pick					
	up						
	[checkmark] Lo	ck bed wheels					
	[added] Swina	shoes for showertennis					
	style shoes/ non :	skid footwear					
	[checkmark] noi	n skid socks					
	1 "	om free of clutter					
	Review of the nu	irsing notes indicated					
	Resident L had fa	_					
	4/2/11 While be	ing accompanied to her					
		aid she was getting weak,					
	knees buckled an						
	4/8/11 Resident	lost balance while talking					
		Front lounge. Fell and					
	bumped head on						
	Campa nead on						
	5/9/11 Resident	missed the chair when					
	she sat down and						
	5/25/11 Residen	t stumbled in shower					

000057

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155132	B. WIN			06/20/2011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					ADOW DR	
DANVILI	LE REGIONAL REH	ABILITATION		DANVII	_LE, IN46122	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		· · · · · · · · · · · · · · · · · · ·	+	TAG	DEFICIENC!)	DATE
	room when gettii	ng ready to use				
	commode.					
	Th C C. 11	(L / . 1 1 .1 C				
	These four falls reflected problems of balance, seating oneself and sudden					
	_					
		bove care plan addressed				
		of falls, but failed to				
	1 *	ess the issues which				
		atic for Resident L except				
	mention of the walker. If the problem					
	was that the resident did not use her					
	walker, it was no	t addressed.				
	3. Resident P's	clinical record was				
		7/11 at 2:20 p.m. His				
		ed, but were not limited				
	1	ls, blind, very hard of				
	hearing, Parkins	on's Disease and 19/11 annual RAI				
	_	nition was severely				
	_	required heavy to full				
		or all areas of daily				
	-	one fall without injury				
	since the previou	is review.				
	Resident P's care	plan indicated it had				
		6/11. The following was				
	the entry address	-				
	life citity address	1115 14115.				
	"Fall/Iniury Asse	essment: Prevention and				
	Management Pla					
	_	column was as follows:				
	"[checkmark] pa					
	[checkmark] stif					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155132		(X2) MI A. BUII		onstruction 00	(X3) DATE S	ETED	
		155132	B. WIN	G		06/20/2	011
NAME OF F	PROVIDER OR SUPPLIER		·	1	ADDRESS, CITY, STATE, ZIP CODE ADOW DR		
DANVILL	E REGIONAL REH	ABILITATION		DANVIL	LE, IN46122		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	[checkmark] uns			1710			DITTE
		diovascular diagnosis					
	[checkmark] box	•					
		dder incontinence					
	[checkmark] der	mentia					
	[checkmark] hea	aring					
	[checkmark] vis	ual					
	[checkmark] car	diovascular meds					
	[checkmark] ant	•					
	[checkmark] ant						
	[checkmark] Par	kinson's"					
	The goal was checked as "will be free of a						
	•	a fall would occur."					
	scrious injury ir a	i fair would occur.					
	The interventions	s were listed as follows:					
	[checkmark] See	e Cardiovascular					
	Circulatory Plan	of Care [checkmark]					
	[checkmark] See	e ADL/Mobility Plan of					
	Care						
	[checkmark] See	e Plan of Care: Pain					
	Management						
		e Alteration in Bowel					
	Elimination Asse						
		e Alteration in Bladder					
	Continence Plan						
	[checkmark] cha						
	[checkmark] bed	_					
	[checkmark] nor	1 SKIU SOCKS					
	It did not address	s how his cognition or					
		mplete dependence					
	might impact his	• •					

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CC A. BUILDING B. WING	00	l' '	ESURVEY PLETED 2011
	PROVIDER OR SUPPLIER E REGIONAL REH		255 ME	ADDRESS, CITY, STATE, ZIP CO EADOW DR LLE, IN46122	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Director of Nurs she acknowledge difficult to follow forms did not en- individualize the realize they're al- other and I did ta regionals about the corporate decision myself."	entries. She stated "I most identical to each alk to the (corporate)				
F0323 SS=D	environment rema hazards as is pos	ensure that the resident ins as free of accident sible; and each resident e supervision and assistance t accidents.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155132 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 255 MEADOW DR DANVILLE REGIONAL REHABILITATION DANVILLE, IN46122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on observation, record review and F0323 Corrective Actions: An incident 07/20/2011 report's for resident T on state interview, the facility failed to ensure form 6-04 has been sent to ISDH side rails were not used except as regarding the identified event . necessary for resident safety. This An investigation regarding safety device assessment has been impacted 1 of 5 residents reviewed for completed. The enablers have safety in the sample of 5 in that siderails been removed and a scoop were being used although observation and mattress has been implemented. the resident's assessment indicated she IDT reviewed care plan and could not use them. (Resident T) resident is now an assist of 2 with turning and repositioning. CNA's have been educated on turning Findings include: and repositioningOther residents having the potential to be During the orientation tour of 6/17/11 at affected: A audit was completed to identify other residents that may 10:46 a.m., Resident T was identified by be affected by alleged deficient RN #2 as having recently had a knot on practice. Any residents identifed her forehead because she hit it on the will be evaluated for appropriate use of enablers and/or safety siderail while being turned. She was devices and implemented or further identified at the time as requiring discontinued according to total care from staff. She was observed assessment. Family notification lying in the middle of her bed which was will be completed. Physician an air mattress. Both side rails were in order will be obtained. Careplans will be updated as appropriate. the up-position. They were the 1/4 sized Systematic changes: side rail and rails which this facility called "enablers." assistive device assessments will be completed upon admission. Clinical record review for Resident T was quarterly, and with change of condition for appropriate completed 6/17/11 at 2:55 p.m. Her placement. Side rail and assistive 5/12/11 quarterly MDS (Minimum Data devices rounds will be completed Set) assessment indicated she was weekly x 4 and monthly x 2 and completely dependent on staff for all then quarterly. Completed by DON/designee for compliance aspects of her daily living and was unless otherwise determined by severely impaired cognitively. She could the QA team. Monitoring: Director not communicate her needs. of Nursing and/or designee will monitor for completion and compliance of above audits and Individual staff interviews were

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155132	- 1	LDING	00	06/20/2	
		100102	B. WIN		DDDEGG CITY GTATE ZID CODE	00/20/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ADOW DR		
DANVILL	LE REGIONAL REH	ABILITATION		1	LE, IN46122		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
		1 between 11 a.m. and 4			placement of assistive devic Completed round Audit trend		
	1 ^	ied nurse aides, one			be reviewed at monthly QA.I		
	1 ~	and three licensed			systematic changes will be		
	1 ^	all indicated Resident T			completed: 7-20-11		
	1	ve a muscle by herself.					
	1	ed or scooted in the bed.					
		ned side to side and					
	_	to do that herself. She					
		rself over by using the					
	siderail.						
	A nursing note of	f 4/21/2011 at 2 p.m.,					
	1	s found to have a 4 cm					
		cm sized, light blue,					
	1 .	right temple/eye area. It					
	1	as "unwitnessed," but					
		e Administrator on					
		, indicated a nurse aide					
	1	'd bumped the resident's					
		rail when she turned her.					
	nedd on the sider	an when she tarned her.					
	Another nursing	note 6/8/2011 at 1:30					
	p.m., indicated a	nurse aide reported					
	finding a golf-ba	ll sized, purplish, raised					
	knot on Resident	T's forehead. Another					
	entry, dated 6/11	/2011 at 10:25 a.m.,					
	indicated, "cont ((continues) to have lg					
	(large) hematoma	a on forehead."					
	6/11/2011 at 6 p.:	m., indicated, "cont. to					
		ring (l) [left] side of					
	forehead." The f	acility's internal					
	investigation had	been inconclusive, but					
	they had surmise	d the resident had					
	bumped her head	l on the siderail during					

000057

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CO A. BUILDING B. WING	00	` ′	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIEF E REGIONAL REH		255 ME	ADDRESS, CITY, STATE, ZIP EADOW DR LLE, IN46122	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	care. During interview interim Director had discussed th and decided to p indicated the nur them removed be the resident wou when they turn he weight indicated pounds on 6/14/	of 6/20/11 at 11 a.m., the of Nursing indicated they is situation that morning ad the siderails. She are aides did not want ecause they were afraid ld roll out of the bed her. Review of her Resident T weighed 89				